STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE FOR ACUPUNCTURE
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
http://tn.gov/health

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS AN ACUPUNCTURE DETOXIFICATION SPECIALIST (ADS)

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee certification to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

		Done
1.	Complete, sign, have notarized and mail the application pages 1 through 6.	
2.	Attach to the application a clear, recognizable, recently taken passport size photograph of yourself.	_____
3.	Have submitted directly from the training program to the Administrative Office documentation of successful completion of a board-approved training program in auricular detoxification acupuncture. To become board-approved, the training program must meet or exceed standards of training set by NADA. See **Attachment 2**.	
4.	If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as an ADS or other health professional, you must complete and mail **Attachment 1** to each and every state. Copies of **Attachment 1** may be duplicated to accommodate each request.	_____
5.	Submit two (2) original letters of recommendation from medical professionals who can attest to your character as an ADS. These letters must be written within the preceding 12 months, identify the individuals as medical professionals, and **must be originals** on the signator's letterhead.	_____
6.	Attach to the application a check or money order in the amount of $110.00 made payable to the Committee for Acupuncture.	
7.	Have submitted directly from an employing institution, facility, or entity to the Administrative Office satisfactory proof of the practice of auricular detoxification treatment in a hospital, clinic, or treatment facility which provides comprehensive alcohol and substance abuse or chemical dependency services including counseling. Accompanying this proof must also be a certification from the supervising certified acupuncturist or medical director of the institution, facility, or entity attesting to employment and acceptance of supervisory responsibility.	_____
8.	Criminal background check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.	_____
9.	All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form, The Declaration of Citizenship is available online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf	_____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Committee's administrative office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

   Tennessee Board of Medical Examiners'
   Committee for Acupuncture
   665 Mainstream Drive
   Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the administrative office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Committee's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet at http://tennessee.gov/health/

6. It is strongly recommended that you do not make arrangements to accept employment as an ADS in Tennessee until you are granted certification by the Committee for Acupuncture.

7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.

8. All documents provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to process your application as quickly as possible.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH

FOR OFFICIAL USE ONLY

2483-001	**$100.00**
2483-006	**$ 10.00**
	$110.00

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APPLICATION FOR CERTIFIED ACUPUNCTURE DETOXIFICATION SPECIALIST (ADS)

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name as it will appear on license: _____
(*First*) (*Middle*) (*Last*)

Have you been known by any other name? Y N If yes, list names: _____

Date of Birth: Mo._____Day_____Yr._____ Social Security Number: ---------- _____

U.S. Citizen: Y N Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component. (If yes, please provide proof of same.) Y N

Present Mailing Address: _____ Home Phone: (_____) _____

_____ Work Phone: (_____) _____

_____ Gender: M F Race: _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Institution/Location Degree Earned

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Institution/Location Degree Earned

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Institution/Location Degree Earned

From: _____ To: _____ _____ _____
MM/YY MM/YY Educational Institution/Location Degree Earned

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	**LOCATION**	**POSITION AND DUTIES**
From: _____ To: _____ MM/YY MM/YY	_____ (Name of Location)	_____ _____
	_____ (City) (State)	_____ _____
From: _____ To: _____ MM/YY MM/YY	_____ (Name of Location)	_____ _____
	_____ (City) (State)	_____ _____
From: _____ To: _____ MM/YY MM/YY	_____ (Name of Location)	_____ _____
	_____ (City) (State)	_____ _____
From: _____ To: _____ MM/YY MM/YY	_____ (Name of Location)	_____ _____
	_____ (City) (State)	_____ _____

LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

	YES	NO
Have you ever previously applied for an ADS certification in Tennessee?	____	____

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application*.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	____

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6. Have you ever held or applied for a license, privilege, registration or certificate to practice as an ADS in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10. Have you ever been rejected or censured by a professional association or society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	___	___
b. Have you ever entered into any settlement of any legal action; or	___	___
c. Are there any legal actions pending against you or to which you are a party?	___	___
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___
14. Have you ever failed a licensure or certification examination?	___	___
If yes, which exam and how many times have you failed? _____		

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I,_____, of_____,
(Applicant's Name) *(City)*
(State)
being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee may find necessary which may include an interview.

RELEASE to the Committee and Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Committee and Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

RELEASE from liability the Committee and Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and/or other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this_____day of_____,_____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

ATTACHMENT 1

STATE OF TENNESSEE
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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____.
(Date)

The Committee for Acupuncture of Tennessee requests that I submit evidence of the current status of that license or certificate in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee for Acupuncture.

_____
Applicant's Signature

Date _____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: (Check One) _____ Endorsement/Reciprocity with _____ (State)

_____ Written Examination _____

Is the license currently active and registered? Yes____ No ____

Is there any derogatory information on file? Yes____ No____ If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

Please mail directly to: Committee for Acupuncture
665 Mainstream Drive
Nashville, TN 37243

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

COMMITTEE FOR ACUPUNCTURE
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TRAINING PROGRAM DOCUMENTATION REQUEST

APPLICANT: supply the information requested in this box and then mail this entire form to your training program.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____
_____
_____
_____

Number of Certificate of Completion: _____

Year of Completion: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as an Acupuncture Detoxification Specialists in the State of Tennessee. Please forward an original verification letter proving my successful completion of a board approved training program that meets or exceeds standards of training set by NADA. Letters should be sent to:

Tennessee Board of Medical Examiners
Committee for Acupuncture
665 Mainstream Drive
Nashville, TN 37243

Thank you for cooperation and prompt response.

_____ _____
Applicant's Signature Date